State of California Department of Consumer Affairs

BOARD OF REGISTERED NURSING
P O Box 944210, Sacramento, CA 94244-2100
TDD (916) 322-1700
Telephone (916) 322-3350
www.rn.ca.gov

Ruth Ann Terry, MPH, RN
Executive Officer

CALIFORNIA BOARD OF REGISTERED NURSING GENERAL INSTRUCTIONS AND APPLICATION REQUIREMENTS REGARDING THE PSYCHIATRIC/MENTAL HEALTH (P/MH) NURSE LISTING

GENERAL INSTRUCTIONS

I. Overview

Pursuant to the amendment of Division 2 of the Insurance Code Section 10176, the Board of Registered Nursing maintains a list of registered nurses who are eligible for direct reimbursement by some health care plans for providing psychiatric/mental health services to insured persons. For reimbursement purposes, the psychiatric/mental health services provided must be covered under the terms of the insured's plan and must be considered necessary by the referring physician.

To be eligible for the listing, the California Registered Nurse must possess a master's degree in psychiatric/mental health nursing and complete two (2) years of supervised clinical experience in providing psychiatric/mental health counseling services. The master's degree in nursing must be directly related to mental health, such as psychiatric/mental health nursing or community mental health nursing.

Validation of the required two (2) years of supervised clinical experience may be obtained in the following manner: **(A)** one (1) year of supervised clinical experience obtained while completing the master's degree in nursing and one (1) year of supervised clinical experience obtained after the master's degree in nursing has been conferred; or two (2) years of supervised clinical experience obtained subsequent to the conferral of the master's degree in nursing; or **(B)** American Nurses Association - American Nurses Credentialing Center (ANCC) verification as a Clinical Specialist in Psychiatric/Mental Health Nursing.

Psychiatric/mental health nurses work under the same scope of regulation as do all registered nurses, and inclusion on the Board's list does not in any way expand the scope of practice of such registered nurses.

GENERAL INSTRUCTIONS (CONT'D)

II. General Application Requirements

Psychiatric/Mental Health Nurse listing eligibility requires the possession of a current, clear and active California RN license. The following must be submitted to the Board of Registered Nursing for Psychiatric/Mental Health Nurse listing purposes:

1. **A completed Psychiatric/Mental Health Nurse Listing Application form (Pages 6 & 7). No fee is required to process the listing application.**
2. **One recent 2" x 2" passport type photograph.**
3. **Required documentation to determine listing eligibility. Please refer to the application requirements for the Psychiatric/Mental Health Nurse listing (Pages 4 & 5) and select the appropriate method by which to qualify.**

If you do not possess a current, clear and active California RN license and have never applied for a California RN license, an Application for California RN Licensure by Endorsement must also be submitted. If you have had a permanent California RN license, you must renew/reactivate the California RN license.

Processing times for the listing may vary, depending on the receipt of documentation from academic programs, associations/national organizations or supervisors. Processing a Psychiatric/Mental Health Nurse listing application indicating a conviction(s), disciplinary action(s) and/or voluntary surrender(s) may take longer. A pending application file is not a public record; therefore, an applicant must sign a release of information before the Board of Registered Nursing will release information to the public, including employers, relatives or other third parties. Once you are listed, your address of record must be disclosed to the public upon request. All requests for information are mandatory.

III. Name and/or Address Changes

California Code of Regulations, Section 1409.1 requires that you notify the Board of Registered Nursing of all name and address changes within thirty (30) days of any change. You may call the Board of Registered Nursing regarding the change of address of record. If you have changed your name, please submit a letter of explanation regarding the requested name change plus applicable documentation such as a copy of a marriage certificate, divorce decree or a driver's license.

IV. Social Security Number

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure, certification or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal of licensure/certification will not be processed. You will be reported to the Franchise Tax Board, who may assess a $100 penalty against you.

GENERAL INSTRUCTIONS (CONT'D)

V. Reporting ALL Conviction(s), Discipline(s) and/or Voluntary Surrender(s) Against Licenses/Certificates/Listings

Applicants are required under law to report ALL misdemeanor and felony convictions. "Driving under the influence" convictions must be reported. Conviction(s) must be reported even if they have been expunged under Penal Code Section 1203.4 or even if a court ordered diversion program has been completed under the Penal Code or under Article 5 of the Vehicle Code. Also, all disciplinary action(s) and/or voluntary surrender(s) against an applicant's psychiatric/mental health nurse, registered nurse, practical nurse, vocational nurse or other professional license/certificate/listing must be reported.

Failure to report prior conviction(s), disciplinary action(s) and/or voluntary surrender(s) is considered falsification of application and is grounds for denial of licensure/certification/listing or revocation of license/certificate/listing.

When reporting prior conviction(s), disciplinary action(s) and/or voluntary surrender(s), **applicants are required to provide a full written explanation of:** circumstances surrounding the arrest(s), conviction(s), disciplinary action(s) and/or voluntary surrender(s); the date of incident(s), conviction(s), disciplinary action(s) and/or voluntary surrender(s); specific violation(s) (cite section of law, if convicted), court location or jurisdiction, sanctions or penalties imposed and completion dates. Certified copies of court documents or state board determinations/decisions should also be included.

NOTE: A certified copy of the arrest report may also be requested. Applicants must also submit a description of the rehabilitative changes in their lifestyle which would enable them to avoid future occurrences.

To make a determination in these cases, the Board of Registered Nursing considers the nature and severity of the offense, additional subsequent acts, recency of acts or crimes, compliance with court sanctions and evidence of rehabilitation.

The burden of proof lies with the applicant to demonstrate acceptable documented evidence of rehabilitation. Examples of rehabilitation evidence include, but are not limited to:

- Recent dated letter from applicant describing rehabilitative efforts or changes in life to prevent future problems.
- Letters of reference on official letterhead from employers, nursing instructors, health professionals, professional counselors, parole or probation officers, or other individuals in positions of authority who are knowledgeable about your rehabilitation efforts.
- Letters from recognized recovery programs and/or counselors attesting to current sobriety and length of time of sobriety, if there is a history of alcohol or drug abuse.
- Proof of community work, schooling, self-improvement efforts.
- Court-issued certificate of rehabilitation or evidence of expungement, proof of compliance with criminal probation or parole, and orders of the court.

All of the above items should be mailed **directly** to the Board of Registered Nursing by the individual(s) or agency who is providing information about the applicant. Have these items

GENERAL INSTRUCTIONS (CONT'D)

sent to the Board of Registered Nursing, Licensing Unit – Advanced Practice (P/MH Listing), P.O. Box 944210, Sacramento, CA 94244-2100.

It is the responsibility of the applicant to provide sufficient rehabilitation evidence on a timely basis so that the listing determination can be made.

An applicant is also required to immediately report, in writing, to the Board of Registered Nursing any conviction(s), disciplinary action(s) and/or voluntary surrender(s) which occur between the date the application was filed and the date that a California Psychiatric/Mental Health listing certificate is issued. Failure to report this information is grounds for denial of licensure/certification or revocation of license/certificate.

NOTE: The application must be completed and signed by the applicant under penalty of perjury.

VI. Address Information

The Board of Registered Nursing's mailing address is:

Advanced Practice Unit – P/MH Listing
Board of Registered Nursing
P. O. Box 944210, Sacramento, CA 94244-2100

The Board of Registered Nursing's street address for overnight mail is:

Advanced Practice Unit – P/MH Listing
Board of Registered Nursing
400 R Street, Suite 4030, Sacramento, CA 95814-6239

VII. California Nursing Practice Act

California statutes and regulations pertaining to Registered Nurses - Psychiatric/Mental Health Nurses may be obtained by contacting:

Procurement Publications Section
California Department of General Services
P. O. Box 1015, North Highlands, CA 95660
Document Number: 7540-957-1108-5 Fee: $9.95
Telephone Number: (916) 928-4630 - No Telephone Orders Accepted
(Above Information Subject to Change)

APPLICATION REQUIREMENTS FOR PSYCHIATRIC/MENTAL HEALTH (P/MH) NURSE LISTING

1. The submission of the **Application for the Psychiatric/Mental Health Nurse Listing** form (Pages 6 & 7) to the Board of Registered Nursing. **No application processing fee is required.**

2. Verification of the Completion of a Psychiatric/Mental Health Academic Program form (Page 8) and **official transcripts** verifying the master's degree in psychiatric/mental health nursing submitted by the academic program directly to the Board of Registered Nursing. Course descriptions for the applicable period of enrollment should accompany official transcripts when the nursing specialty area for the master's degree is not clearly identified.

APPLICATION REQUIREMENTS FOR PSYCHIATRIC/MENTAL HEALTH (P/MH) NURSE LISTING (CONT'D)

3. Submission of **one** (1) of the applicable forms **A (Page 9) or B (Page 10)** to the Board of Registered Nursing to satisfy the supervised clinical experience requirement.

A. Verification of Supervision of Clinical Experience - Page 9

Verification of two (2) years of clinical experience in providing psychiatric/mental health counseling services under the supervision of one or more of the following professionals with current training and practice as well as a current, clear and active license:

- A psychiatric/mental health nurse listed with the California Board of Registered Nursing.
- A licensed clinical psychologist.
- A licensed clinical social worker.
- A licensed marriage, family and child counselor.
- A psychiatrist.

The supervised clinical experience for the provision of psychiatric/mental health counseling services may be satisfied by evidencing that the required two (2) years of clinical experience was completed in the following manner:

- One (1) year obtained while completing the master's degree in nursing and one (1) year after the master's degree in nursing had been conferred; **OR**
- Two (2) years obtained subsequent to the conferral of the master's degree in nursing.

If one professional did not supervise the entire two (2) year period, the verification form must be submitted by each supervisor to evidence the completion of the required supervised clinical experience during the two (2) year period. The two (2) year period does not need to be consecutive years.

Applicants whose experience had been acquired outside of California must provide evidence that at the time the experience was obtained, the supervisor was currently licensed, certified or registered to provide psychiatric/mental health counseling services by a state agency whose standards are equivalent to or greater than those required by the equivalent licensing agency in California.

B. Verification of Psychiatric/Mental Health Certification by a National Association - Page 10

American Nurses Association - American Nurses Credentialing Center (ANCC)* verification that the applicant is currently certified as a Clinical Specialist in Psychiatric/Mental Health Nursing. The verification form must be submitted directly to the Board of Registered Nursing by ANCC.

*** American Nurses Association - American Nurses Credentialing Center (ANCC)**
600 Maryland Ave., SW, Suite 100 West, Washington, DC 20024-2571
(800) 284-2378 http://www.nursingworld.org/ancc
(Above Information Subject to Change)

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APPLICATION FOR THE LISTING AS A PSYCHIATRIC/MENTAL HEALTH (P/MH) NURSE
(NO FEE REQUIRED FOR PROCESSING)

A. PERSONAL DATA (Please print or type):

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address of Record: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home ( ) Work ( )	Mother's Maiden Name:

B. RN LICENSURE:

California RN License Number:	Date Issued:	Expiration Date:
List **ALL** States Where You Hold/Held an RN License and Status:		
Original State of RN Licensure: RN License Number:	Date Issued:	Expiration Date:

C. RN EDUCATION:

Name of Professional Registered Nursing Program:	Location: (City) (State or Country)	
Type of RN Program: ☐ ADN ☐ DIP ☐ BSN ☐ MSN	Entrance Date:	Graduation/Completion Date:

D. PSYCHIATRIC/MENTAL HEALTH EDUCATION:

Name of Psychiatric/Mental Health Nursing Academic Program:	Location: (City) (State or Country)	
Entrance Date:	Graduation/Completion Date:	Nursing Specialty of Master's Degree:

E. SUPERVISED CLINICAL EXPERIENCE IN PSYCHIATRIC/MENTAL HEALTH COUNSELING:

Beginning and Ending Dates:	Supervisor's Name and Profession:	Briefly Describe the Nature of Your Clinical Experience and State Where It Was Obtained:

F. PSYCHIATRIC/MENTAL HEALTH NURSE PROFESSIONAL CERTIFICATION (If Applicable):

Name of Association: Area of Specialization:	Original Date of Certification:
Certification Number:	Current Renewal/Recertification Cycle Dates:
Method of Certification: ☐ Examination ☐ Other (Please Explain)	

G. BACKGROUND INFORMATION:

I. Have you ever **applied** for a Psychiatric/Mental Health Nurse listing in California? If yes: Name at Time of Application: _____Date Submitted:_____	Yes ☐ No ☐
II. Have you ever been **issued** a Psychiatric/Mental Health Nurse listing in California? If yes: **STOP. DO NOT CONTINUE.** Please contact the Board regarding whether you should reapply or file a petition for reinstatement of your Psychiatric/Mental Health Nurse listing.	Yes ☐ No ☐
III. Have you ever been convicted of **ANY** offense other than minor traffic violations? If yes, please explain fully as described in the General Instructions - Section V. Convictions must be reported even if they have been expunged under Penal Code Section 1203.4 or if a diversion program has been completed under the Penal Code or Article 5 of the Vehicle Code. Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes convictions following a plea of nolo contendre (no contest), as well as pleas or verdicts of guilty. **YOU MUST INCLUDE MISDEMEANORS AS WELL AS FELONY CONVICTIONS.**	Yes ☐ No ☐
IV. Have you ever had a health-care related license/certificate/listing to practice nursing revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions - Section V.	Yes ☐ No ☐
V. Have you ever had a professional or vocational license/certificate/listing to practice revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions - Section V.	Yes ☐ No ☐

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of **ANY** offense that occurs between the date of this application and the date that a California Psychiatric/Mental Health Nurse listing is issued. I am also required to report to the California Board of Registered Nursing **ANY** disciplinary action and/or voluntary surrender against **ANY** health-care related license/certificate/listing that occurs between the date of this application and the date that a California Psychiatric/Mental Health Nurse listing is issued. I understand that failure to do so may result in denial of this application or subsequent disciplinary action against my license/certificate/listing.

I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with this application for the Psychiatric/Mental Health Nurse listing is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure/certification/listing or licensure/certification/listing revocation in California.

SIGNATURE OF APPLICANT:_____

DATE:_____

NOTE:

PLEASE TAPE A RECENT 2" x2" PASSPORT SIZE PHOTOGRAPH

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VERIFICATION OF THE COMPLETION OF A PSYCHIATRIC/MENTAL HEALTH (P/MH) ACADEMIC PROGRAM

A. TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the Psychiatric/Mental Health nursing academic program for completion. Official transcripts submitted must include all completed course work with the master's degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts. Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home ( ) Work ( )	California RN License Number: Expiration Date:
Name of Master's Degree Nursing Program:	
Entrance and Completion Dates:	Specialty:

Signature of Applicant:_____Date:_____

B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE PSYCHIATRIC/MENTAL HEALTH NURSING ACADEMIC PROGRAM: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Master's Degree Nursing Program:	Telephone Number: ( )
Address: (Number & Street) (City) (State) (Zip Code)	
Nursing Specialty:	Date Master's Degree Status Conferred:
Entrance and Completion Dates: From: (Month) (Day) (Year)	To: (Month) (Day) (Year)

I certify under penalty of perjury that the documentation regarding the completion of the Psychiatric/Mental Health master's nursing academic program for the above named applicant is true and correct.

Signature:_____ Date:_____

Title:_____ Telephone Number:(_____)_____

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A. VERIFICATION OF SUPERVISION OF CLINICAL EXPERIENCE (P/MH)

A. INFORMATION TO BE COMPLETED BY THE APPLICANT: Please complete Part A of the form and submit to your supervisor for completion. If more than one (1) supervisor supervised during the two (2) year period, the form must be submitted by each supervisor. Please print or type.

Name:_____
(Last) (First) (Middle)

California RN License Number: _____ Expiration Date:_____

Telephone Number: (_____)_____ Social Security Number (Mandatory):_____

B. INFORMATION TO BE COMPLETED BY SUPERVISOR: Please complete Part B of the form regarding the above named applicant and submit to the Board of Registered Nursing.

Name of Supervisor: _____Telephone Number: (_____)_____

Address: _____
(Number & Street) (City) (State) (Zip Code)

Profession: _____Licensed By: _____

License Number: _____Expiration Date:_____ Social Security Number: _____

Location of Clinical Experience:_____
(Name of Agency) (Address)

Level of Supervision Provided:_____

Summary of the nature of cases, types of treatment and/or appropriate interventions carried out by the above named applicant during the specified period of supervision for the provision of psychiatric/mental health counseling services:

_____

_____

_____

_____

_____

_____

I hereby certify under penalty of perjury that the above is true and correct and that I supervised the above named applicant in providing psychiatric/mental health counseling services to clients during the period:

From:_____ To:_____ For:_____ Hours Per Week = _____.
Month) (Day) (Year) (Month) (Day) (Year) (Number of) (Cumulative Hours)

Signature of Supervisor:_____Date: _____

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B. VERIFICATION OF PSYCHIATRIC/MENTAL HEALTH (P/MH) CERTIFICATION BY A NATIONAL ASSOCIATION

A. TO BE COMPLETED BY APPLICANT: Please complete Part A and submit to the American Nurses Association - American Nurses Credentialing Center (ANCC) to verify your clinical specialist in psychiatric/mental health nursing certification status. **A fee is required by ANCC for processing the verification form.** Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home ( ) Work ( )	California RN License Number: Expiration Date:
Name of Master's Degree Nursing Program:	
Entrance and Completion Dates:	Specialty:
Signature of Applicant:_____	Date:_____

B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ASSOCIATION: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Certifying National Association:	Telephone Number: ( )
Address: (Number & Street) (City) (State) (Zip Code)	Method of Certification:
Certificate Number: Original Date of Certification:	**CNS Certification Specialty:**
Current Renewal Cycle Dates for Certification/Recertification: From: (Month) (Year) To: (Month) (Year) (If not applicable, please explain.)	

I certify under penalty of perjury that the clinical specialist in psychiatric/mental health nursing certification status for the above named applicant is true and correct.

Signature:_____ Date:_____

Title:_____ Telephone Number:(_____)_____ **(OFFICIAL SEAL)**